List of Subjects

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 419

Hospitals, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services propose to amend 42 CFR chapter IV as follows:

PART 413--PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

A. Part 413 is amended as set forth below:

1. The authority citation for part 413 continues to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395f(b), 1395g, 1395l, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww).

Subpart B--Accounting Records and Reports

2. In §413.24, the heading to paragraph (d) is republished, paragraph (d)(6) is revised, and a new paragraph (d)(7) is added, to read as follows:

§413.24 Adequate cost data and cost finding.

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(d) Cost finding methods. * * *

(6) Provider-based entities and departments: Preventing duplication of cost. In some situations, the main provider in a provider-based complex may purchase services for a provider-based entity or for a department of the provider through a contract for services (for example, a management contract), directly assigning the costs to the provider-based entity or department and reporting the costs directly in the cost center for that entity or department. In any situation in which costs are directly assigned to a cost center, there is a risk of excess cost in that cost center resulting from the directly assigned costs plus a share of overhead improperly allocated to the cost center which duplicates the directly assigned costs. This duplication could result in improper Medicare payment to the provider. Where a provider has purchased services for a provider-based entity or for a provider department, like general service costs of the provider (for example, like costs in the administrative and general cost center) must be separately identified to ensure that they are not improperly allocated to the entity or the department. If the like costs of the main provider cannot be separately identified, the costs of the services purchased through a

contract must be reclassified to the main provider and allocated among the main provider's benefiting cost centers.

Example: A provider-based complex is composed of a hospital and a hospital-based rural health clinic (RHC). The hospital furnishes the entirety of its own administrative and general costs internally. The RHC, however, is managed by an independent contractor through a management contract. The management contract provides a full array of administrative and general services, with the exception of patient billing. The hospital directly assigns the costs of the RHC's management contract to the RHC cost center (for example, Form HCFA 2552-96, Worksheet A, Line 71). A full allocation of the hospital's administrative and general costs to the RHC cost center would duplicate most of the RHC's administrative and general costs. However, an allocation of the hospital's cost (included in hospital administrative and general costs) of its patient billing function to the RHC would be appropriate. Therefore, the hospital must include the costs of the patient billing function in a separate cost center to be allocated to the benefiting cost centers,

including the RHC cost center. The remaining hospital administrative and general costs would be allocated to all cost centers, excluding the RHC cost center. If the hospital is unable to isolate the costs of the patient billing function, the costs of the RHC's management contract must be reclassified to the hospital administrative and general cost center to be allocated among all cost centers, as appropriate.

(7) Costs of services furnished to free-standing entities. The costs that a provider incurs to furnish services to free-standing entities with which it is associated are not allowable costs of that provider. Any costs of services furnished to a free-standing entity must be identified and eliminated from the allowable costs of the servicing provider, to prevent Medicare payment to that provider for those costs. This may be done by including the free-standing entity on the cost report as a nonreimbursable cost center for the purpose of allocating overhead costs to that entity. If this method would not result in an accurate allocation of costs to the entity, the provider must develop detailed work papers showing how the cost of services furnished by the provider to the

entity were determined. These costs are removed from the applicable cost centers of the servicing provider.

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Subpart E--Payments to Providers

3. Section 413.65 is amended as follows:

A. Revising paragraph (a)(1).

B. Revising the definition of "Provider-based entity" in paragraph (a)(2).

C. Revising paragraph (b).

D. Revising paragraph (c).

E. Revising the introductory text to paragraph (d).

F. Revising paragraph (d)(7).

G. Revising paragraph (g)(7).

H. Revising the introductory text to paragraph (i)(1).

I. Revising paragraph (i)(1)(ii).

J. Revising paragraph (i)(2).

The revisions read as follows:

§413.65 Requirements for a determination that a facility or an organization has provider-based status.

(a) Scope and definitions. (1) Scope. (i) This section applies to all facilities for which provider-based

status is sought, including remote locations of hospitals, as defined in paragraph (a)(2) of this section and satellite facilities as defined in §412.22(h)(1) and §412.25(e)(1) of this chapter, other than facilities described in paragraph (a)(1)(ii) of this section.

(ii) This section does not apply to the following facilities:

(A) Ambulatory surgical centers (ASCs).

(B) Comprehensive outpatient rehabilitation facilities (CORFs).

(C) Home health agencies (HHAs).

(D) Skilled nursing facilities (SNFs).

(E) Hospices.

(F) Inpatient rehabilitation units that are excluded from the inpatient PPS for acute hospital services.

(G) Independent diagnostic testing facilities and any other facilities that furnish only clinical diagnostic laboratory tests.

(H) Facilities furnishing only physical, occupational, or speech therapy to ambulatory patients, for as long as the $1,500 annual cap on coverage of physical, occupational, and speech therapy, as described in

section 1833(g)(2) of the Act, remains suspended by the action of subsequent legislation.

(I) ESRD facilities (determinations for ESRD facilities are made under §413.174 of this chapter).

(2) Definitions. * * *

* * * * *

Provider-based entity means a provider of health care services, or an RHC as defined in §405.2401(b) of this chapter, that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of a different type from those of the main provider under the name, ownership, and administrative and financial control of the main provider, in accordance with the provisions of this section.

* * * * *

(b) Provider-based determinations. (1) A facility or organization is not entitled to be treated as provider-based simply because it or the main provider believe it is provider-based.

(2) If a facility was treated as provider-based in relation to a hospital or CAH on October 1, 2000, it will continue to be considered provider-based in relation to

that hospital or CAH until October 1, 2002, and the requirements, limitations, and exclusions specified in paragraphs (d), (e), (f), and (h) of this section will not apply to that hospital or CAH for that facility until October 1, 2002. For purposes of this paragraph, a facility will be considered to have been treated as provider-based on October 1, 2000, if on that date it either had a written determination from CMS that it was provider-based as of that date, or was billing and being paid as a provider-based department or entity of the hospital.

(3) Except as specified in paragraphs (b)(2) and (b)(5) of this section, a main provider or a facility must contact CMS, and the facility must be determined by CMS to be provider-based, before the main provider bills for services of the facility as if the facility were provider-based, or before it includes costs of those services on its cost report.

(4) A facility that is not located on the campus of a hospital and that is used as a site where physician services of the kind ordinarily furnished in physician offices are furnished is presumed to be a free-standing

facility, unless it is determined by CMS to have provider-based status.

(5) A facility for which a determination of provider-based status in relation to a hospital or CAH is requested on or after October 1, 2000 and before October 1, 2002 will be treated as provider-based in relation to the hospital or CAH from the first date on or after October 1, 2000 on which the facility was licensed (to the extent required by the State), staffed and equipped to treat patients until the date on which CMS determines that the facility does not qualify for provider-based status.

(c) Reporting. A main provider that has had one or more facilities considered provider-based also must report to CMS any material change in the relationship between it and any provider-based facility, such as a change in ownership of the facility or entry into a new or different management contract that could affect the provider-based status of the facility.

(d) Requirements. An entity must meet all of the following requirements to be determined by CMS to have provider-based status.

* * * * *

(7) Location in immediate vicinity. The facility or organization and the main provider are located on the same campus, except when the requirements in paragraphs (d)(7)(i), (d)(7)(ii), or (d)(7)(iii) of this section are met:

(i) The facility or organization is located within a 35-mile radius of the main campus of the hospital or CAH that is the potential main provider;

(ii) The facility or organization is owned and operated by a hospital or CAH that has a disproportionate share adjustment (as determined under §412.106 of this chapter) greater than 11.75 percent or is described in §412.106(c)(2) of this chapter implementing section 1886(d)(5)(F)(i)(II) of the Act and is--

(A) Owned or operated by a unit of State or local government;

(B) A public or nonprofit corporation that is formally granted governmental powers by a unit of State or local government; or

(C) A private hospital that has a contract with a State or local government that includes the operation of clinics located off the main campus of the hospital to

assure access in a well-defined service area to health care services to low-income individuals who are not entitled to benefits under Medicare (or medical assistance under a Medicaid State plan).

(iii) The facility or organization demonstrates a high level of integration with the main provider by showing that it meets all of the other provider-based criteria and demonstrates that it serves the same patient population as the main provider, by submitting records showing that, during the 12-month period immediately preceding the first day of the month in which the application for provider-based status is filed with CMS, and for each subsequent 12-month period--

(A) At least 75 percent of the patients served by the facility or organization reside in the same zip code areas as at least 75 percent of the patients served by the main provider;

(B) At least 75 percent of the patients served by the facility or organization who required the type of care furnished by the main provider received that care from that provider (for example, at least 75 percent of the patients of an RHC seeking provider-based status received inpatient

hospital services from the hospital that is the main provider); or

(C) If the facility or organization is unable to meet the criteria in paragraph (d)(7)(i)(A) or (d)(7)(i)(B) of this section because it was not in operation during all of the 12-month period described in the previous sentence, the facility or organization is located in a zip code area included among those that, during all of the 12-month period described in the previous sentence, accounted for at least 75 percent of the patients served by the main provider.

(iv) A facility or organization is not considered to be in the "immediate vicinity" of the main provider unless the facility or organization and the main provider are located in the same State or, when consistent with the laws of both States, adjacent States.

(v) An RHC that is otherwise qualified as a provider-based entity of a hospital that is located in a rural area, as defined in §412.62(f)(1)(iii) of this chapter, and has fewer than 50 beds, as determined under §412.105(b) of this chapter, is not subject to the criteria in paragraphs (d)(7)(i) through (d)(7)(iv) of this section.

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(g) Obligations of hospital outpatient departments and hospital-based entities. * * *

* * * * *

(7) When a Medicare beneficiary is treated in a hospital outpatient department or hospital-based entity (other than an RHC) that is not located on the main provider's campus, the hospital has a duty to provide written notice to the beneficiary, before the delivery of services, of the amount of the beneficiary's potential financial liability (that is, of the fact that the beneficiary will incur a coinsurance liability for an outpatient visit to the hospital as well as for the physician service, and of the amount of that liability). The notice must be one that the beneficiary can read and understand. If the exact type and extent of care needed is not known, the hospital may furnish a written notice to the patient that explains the fact that the beneficiary will incur a coinsurance liability to the hospital that he or she would not incur if the facility were not provider-based. The hospital may furnish an estimate based on typical or average charges for visits to the facility,

while stating that the patient's actual liability will depend upon the actual services furnished by the hospital. If the beneficiary is unconscious, under great duress, or for any other reason unable to read a written notice and understand and act on his or her own rights, the notice must be provided, before the delivery of services, to the beneficiary's authorized representative.

* * * * *

(i) Inappropriate treatment of a facility or organization as provider-based. (1) Determination and review. If CMS learns that a provider has treated a facility or organization as provider-based and the provider had not obtained a determination of provider-based status under this section, CMS will--

* * * * *

(ii) Investigate and determine whether the requirements in paragraph (d) of this section (or, for periods before the beginning of the hospital's first cost reporting period beginning or or after January 10, 2001, the requirements in applicable program instructions) were met; and

* * * * *

(2) Recovery of overpayments. If CMS finds that payments for services at the facility or organization have been made as if the facility or organization were provider-based, even though CMS had not previously determined that the facility or organization qualified for provider-based status, CMS will recover the difference between the amount of payments that actually were made and the amount of payments that CMS estimates should have been made in the absence of a determination of provider-based status, except that recovery will not be made for any period before the beginning of the hospital's first cost reporting period beginning or or after January 10, 2001 if during all of that period the management of the entity made a good faith effort to operate it as a provider-based facility or organization, as described in paragraph (h)(3) of this section.

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PART 419--PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

B. Part 419 is amended as set forth below:

1. The authority citation for part 419 continues to read as follows:

Authority: Secs. 1102, 1833(t), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395l(t), and 1395hh).

PART 419--PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

SUBPART A--GENERAL PROVISIONS

2. In §419.2, paragraph (c) is revised to read as follows:

§419.2 Basis of payment.

* * * * *

(c) Determination of hospital outpatient prospective payment rates: Excluded costs. The following costs are excluded from the hospital outpatient prospective payment system.

(1) The costs of direct graduate medical education activities as described in § 413.86 of this chapter.

(2) The costs of nursing and allied health programs as described in § 413.85 of this chapter.

(3) The costs associated with interns and residents not in approved teaching programs as described in § 415.202 of this chapter.

(4) The costs of teaching physicians attributable to Part B services for hospitals that elect cost-based reimbursement for teaching physicians under § 415.160.

(5) The reasonable costs of anesthesia services furnished to hospital outpatients by qualified nonphysician anesthetists (certified registered nurse anesthetists and anesthesiologists' assistants) employed by the hospital or obtained under arrangements, for hospitals that meet the requirements under § 412.113(c) of this chapter.

(6) Bad debts for uncollectible deductibles and coinsurances as described in § 413.80(b) of this chapter.

(7) Organ acquisition costs paid under Part B.

(8) Corneal tissue acquisition costs.

SUBPART B--CATEGORIES OF HOSPITALS AND SERVICES SUBJECT TO AND EXCLUDED FROM THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

3. In §419.20, paragraph (a) is revised, and paragraphs (b)(3) and (b)(4) are added to read as follows:

§419.20 Hospitals subject to the hospital outpatient prospective payment system.

(a) Applicability. The hospital outpatient prospective payment system is applicable to any hospital

participating in the Medicare program, except those specified in paragraph (b) of this section, for services furnished on or after August 1, 2000.

(b) Hospitals excluded from the outpatient prospective payment system.

* * * * *

(3) A hospital located outside one of the 50 States, the District of Columbia, and Puerto Rico is excluded from the hospital outpatient prospective payment system.

(4) A hospital of the Indian Health Service.

4. In §419.22, the introductory text is republished, and paragraph (r) is added to read as follows:

§419.22 Hospital outpatient services excluded from payment under the hospital outpatient prospective payment system.

The following services are not paid for under the hospital outpatient prospective payment system:

* * * * *

(r) Services defined in §419.21(b) that are furnished to inpatients of hospitals that do not submit claims for outpatient services under Medicare Part B.

SUBPART C--BASIC METHODOLOGY FOR DETERMINING PROSPECTIVE PAYMENT RATES FOR HOSPITAL OUTPATIENT SERVICES

5. In §419.32, paragraph (b)(1) is revised to read as follows:

§419.32 Calculation of prospective payment rates for hospital outpatient services.

* * * * *

(b) Conversion factor for calendar year 2000 and subsequent years. (1) Subject to paragraph (b)(2) of this section, the conversion factor for a calendar year is equal to the conversion factor calculated for the previous year adjusted as follows:

(i) For calendar year 2000, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act reduced by one percentage point.

(ii) For calendar year 2001--

(A) For services furnished on or after January 1, 2001 and before April 1, 2001, by the hospital inpatient market basket percentage increase applicable under section

1886(b)(3)(B)(iii) of the Act reduced by one percentage point; and

(B) For services furnished on or after April 1, 2001 and before January 1, 2002, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act, and increased by a transitional percentage allowance equal to 0.32 percent.

(iii) For calendar year 2002, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act reduced by one percentage point, without taking into account the transitional percentage allowance referenced in §419.32(b)(ii)(B).

(iv) For calendar year 2003 and subsequent years, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act.

* * * * *

SUBPART D--PAYMENTS TO HOSPITALS

6. In §419.40, the word "coinsurance" is removed and the word "copayment" is added in its place as follows:

§419.40 Payment concepts.

(a) In addition to the payment rate described in §419.32, for each APC group there is a predetermined beneficiary copayment amount as described in §419.41(a). The Medicare program payment amount for each APC group is calculated by applying the program payment percentage as described in §419.41(b).

(b) For purposes of this section--

(1) Coinsurance percentage is calculated as the difference between the program payment percentage and 100 percent. The coinsurance percentage in any year is thus defined for each APC group as the greater of the following: the ratio of the APC group unadjusted copayment amount to the annual APC group payment rate, or 20 percent.

(2) Program payment percentage is calculated as the lower of the following: the ratio of the APC group payment rate minus the APC group unadjusted copayment amount, to the APC group payment rate, or 80 percent.

(3) Unadjusted copayment amount is calculated as 20 percent of the wage-adjusted national median of charges for services within an APC group furnished during 1996, updated to 1999 using an actuarial projection of charge increases

for hospital outpatient department services during the period 1996 to 1999.

(c) Limitation of copayment amount to inpatient hospital deductible amount. The copayment amount for a procedure performed in a year cannot exceed the amount of the inpatient hospital deductible established under section 1813(b) of the Act for that year.

7. Amend §419.41 as follows:

A. The word "coinsurance" is removed each time it appears, and the word "copayment" is added in its place.

B. Paragraph (c)(4)(ii) is redesignated as paragraph (c)(4)(iv).

C. Paragraphs (c)(4)(ii) and (c)(4)(iii) are added as follows:

§419.41 Calculation of national beneficiary copayment amounts and national Medicare program payment amounts.

(c) * * *

* * * * *

(4) * * *

(ii) Effective for services furnished from April 1, 2001 through December 31, 2001, the national unadjusted

coinsurance rate for an APC cannot exceed 57 percent of the prospective payment rate for that APC.

(iii) The national unadjusted coinsurance rate for an APC cannot exceed 55 percent in calendar years 2002 and 2003; 50 percent in calendar year 2004; 45 percent in calendar year 2005; and 40 percent in calendar year 2006 and thereafter.

* * * * *

8. In §419.42 paragraph (a), (c), and (e) are revised as follows:

§419.42 Hospital election to reduce coinsurance.

(a) A hospital may elect to reduce coinsurance for any or all APC groups on a calendar year basis. A hospital may not elect to reduce copayment amounts for some, but not all, services within the same group.

* * * * *

(c) The hospital's election must be properly documented. It must specifically identify the APCs to which it applies and the copayment amount (within the limits identified below) that the hospital has selected for each group.

* * * * *

(e) In electing reduced coinsurance, a hospital may elect a copayment amount that is less than that year's wage-adjusted copaymentamount for the group but not less than 20 percent of the APC payment rate as determined in § 419.32.

* * * * *

§419.43 [Amended]

9. Section 419.43 is amended by removing the word "coinsurance" from the section heading and from paragraph (a), and adding the word "copayment" in its place.

SUBPART G--TRANSITIONAL CORRIDORS

10. In §419.70, paragraph (d)(2) is revised to read as follows:

§419.70 Transitional adjustment to limit decline in payment.

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(d) Hold harmless provisions * * *

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(2) Permanent treatment for cancer hospitals and children's hospitals. In the case of a hospital described in §412.23(d) or §412.23(f) of this chapter for which the prospective payment system amount is less than the pre-BBA amount for covered hospital outpatient services, the amount

of payment under this part is increased by the amount of this difference.

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PART 489--PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

C. Part 489 is amended as set forth below:

1. The authority citation to part 489 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart B--Essentials of Provider Agreements

2. In §489.24, paragraph (i)(2)(ii) is revised to read as follows:

§489.24 Special responsibilities of Medicare hospitals in emergency cases.

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(i) Off-campus departments. * * *

(2) Protocols for off-campus departments. * * *

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(ii) If the off-campus department is a physical therapy, radiology, or other facility not routinely staffed with physicians, RNs, or LPNs, the department's personnel must be given protocols that direct them to contact

emergency personnel at the main hospital campus for direction. Under this direction, and in accordance with protocols established in advance by the hospital, the personnel at the off-campus department must describe patient appearance and report symptoms and, if appropriate, either arrange transportation of the individual to the main hospital campus in accordance with paragraph (i)(3)(i) of this section or assist in an appropriate transfer as described in paragraphs (i)(3)(ii) and (d)(2) of this section. Any contact with emergency personnel at the main hospital campus should either be made after or concurrently with the actions needed to arrange an appropriate transfer under paragraph (i)(3)(ii) of this section if doing otherwise would significantly jeopardize the life or health of the individual.

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(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare--Hospital Insurance; and Program No. 93.774, Medicare--Supplementary Medical Insurance Program)

Dated: _____

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Thomas A. Scully,

Administrator,

Centers for Medicare & Medicaid Services.

Approved: _____

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Tommy G. Thompson,

Secretary.

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